

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 5

1. PLACE OF DEATH:

County CalvertCity or town P. Frederick, Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County CalvertCity or town North Beach Park
(If outside city or town limits, write RURAL and give nearest town)Street No. ?
(If rural, give LOCATION)2.(a) If veteran, name war ?

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

M

6.(b) Name of husband or wife Margaret Accardy6.(c) If alive, give age 10/4 years

7. Birth date of deceased (mo., day, yr.)

Aug. 22, 1883

8. AGE:

Years

Months

Days

If less than one day

64

1

13

hrs.

min.

9. Birthplace

Italy

(Town, county, and state)

10. Usual occupation

Machinist

11. Industry or business

FATHER

12. Name

Vitto Accardy

13. Birthplace

Italy

14. Maiden name

Marie ?

15. Birthplace

Italy

16. Informant

Address

Margaret Accardy
North Beach Park17. Burial
(Burial, cremation, or removal. Which?)

Date thereof

Oct. 8, 1947
(month) (day) (year)

Cemetery or crematory

Congressional Cem.

Location

Wash. D. C.

18. Funeral director

Address

D. D. Harkness & Son
Mt. Airy, Md19. 10/7
(Date rec'd by registrar)

19

47

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5, 1947 at 5:40 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

10/4 to 10/4, to 10/4
and that I last saw him alive on 10/4 to 10/4

Immediate cause of death

Ch. myocarditis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 5 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Huntingtown Date signed 10/6/47

RECEIVED

OCT 8 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County... *Cybert*
 City or town... *Pr. Fred.*
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Baby Girl Brodeur.

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife.

7. Birth date of deceased (mo., day, yr.)

28 Oct 47

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

7

hrs.

min.

9. Birthplace.

Pr. Fred. Md. Dist.
(Town, county, and state)

10. Usual occupation.

11. Industry or business.

MOTHER FATHER

12. Name.

13. Birthplace.

14. Maiden name.

15. Birthplace.

16. Informant.

Address

17.

(Burial, cremation, or removal, which?)

Date thereof.

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

*47**Oct. 29/47*
St. Pauls
Lusby Md.
Almy Gatter - Uncle
St. Demas Md.
10/29
H. Neward
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.

County.

City or town.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war.

MEDICAL CERTIFICATION

20. DATE OF DEATH.

28 Oct 47

19.

at

11 30

p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

21 Oct 47

19.

47

to

28 Oct 47

19.

47

and that I last saw him alive on

28 Oct 47

19.

47

Immediate cause of death

The mother

DURATION

Due to.

Due to.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

10/29/47

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OCT 30 1947

BUREAU 8

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08858

1. PLACE OF DEATH:

County Cabnet
 City or town Susby, Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death Life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Md County Cabnet
 City or town Susby
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 720
 (If rural, give LOCATION)
 2.(a) If veteran, name war.

3. (a) FULL NAME

Laura G. Howell

3. (b) Social Security Number

820

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W

6. (b) Name of husband or wife

J. Benjamin Howell

7. Birth date of deceased (mo., day, yr.)

Jan. 24, 1867

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

8088

hrs.

min.

9. Birthplace

Cabnet County, Md
(Town, county, and state)

10. Usual occupation

Home

11. Industry or business

FATHER

12. Name

John C. Chambers
Md.

13. Birthplace

MOTHER

14. Maiden name

Margaret Ogden
Md

15. Birthplace

16. Informant

Mrs. H. B. Dineen
Susby, Md

Address

17. Burial

Burial
(Burial, cremation, or removal. Which?)

Date thereof

Oct 5, 1947
(month) (day) (year)

Cemetery or crematory

St. Pauls

Location

Susby, Md

18. Funeral director

A. A. Warkner & Son
Mt. Airy, Md

Address

19. (Date rec'd by registrar)

Oct 5 - 47W. J. Parker

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2, 1947 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 27, 1947 to Oct 2, 1947and that I last saw him alive on Oct 2, 1947

Immediate cause of death

Coronary occlusion

Due to

Hypertension c.v.d.

Due to

Other conditions

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

J. del Villar
W. J. Parker
M. D. or RegistrarAddress..... Date signed Oct 3, 47

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OCT 14 1947
BUREAU 9

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MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore
61
08894 #164
Reg. Dist. No. 61

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County... Cabot
City or town... Broomes Island
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?... 2 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?...

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... MD County... Cabot
City or town... Broomes Island
(If outside city or town limits, write RURAL and give nearest town)
Street No...
(If rural, give LOCATION)
2.(a) If veteran, name war... no

3. (a) FULL NAME

Carl Halley

3. (b) Social Security Number

577-07-3125

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

M

6.(b) Name of husband or wife

Lillian Halley

6.(c) If alive, give age... years

66

7. Birth date of deceased (mo., day, yr.)

Oct. 17, 1880

8. AGE:

Years

Months

Days

If less than one day

66

11

21

hrs.

min.

9. Birthplace

Charles Co., Md.
(Town, county, and state)

10. Usual occupation

Stationary Engineer

11. Industry or business

FATHER
MOTHER

12. Name

Jacobus Halley

13. Birthplace

Md.

14. Maiden name

Virginia

15. Birthplace

Md.

16. Informant

Lillian Halley

Address

Broomes Island, Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

Oct. 11, 1947
(month) (day) (year)

Cemetery or crematory

Cedar Hill Cemetery

Location

Washington, D. C.

18. Funeral director

G. G. Hackens & Son

Address

Mt. Airy, Md.

19.

10/10
(Date rec'd by registrar)

19.

47

J. H. Woodward
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... October 8 1947, at 2:10 P. M.

21. I CERTIFY that death occurred on the date above stated; That I attended deceased from

19... 10... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death

Central Nervous System

Due to

Hypertension

Due to

Myocardial Infarction

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

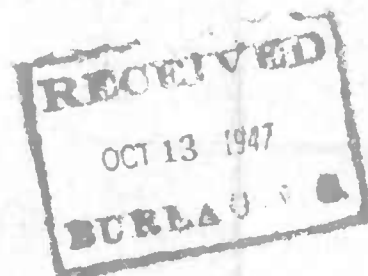
23. SIGNATURE

Page J. J. J.

M. D. or other

John J. J.

Date signed 10/10/47



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08895

Reg. Dist. No. 58

1. PLACE OF DEATH:

County CalvertCity or town Appelton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Annie Oliver

4. Sex

F

5. Color or race

C.

6. (a) Single, married, widowed, or divorced

X

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Nov 5, 1883

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

64

..... hrs. min.

9. Birthplace

md

(Town, county, and state)

10. Usual occupation

domestic

11. Industry or business

FATHER

12. Name

John Johnson

13. Birthplace

md.

14. Maiden name

Jane Bishop

15. Birthplace

md

16. Informant

Annie Gross

Address

Lusby Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

10-12-47
(month) (day) (year)

Cemetery or crematory

St Johns

Location

Calvert

18. Funeral director

P. E. Sewell

Address

Prince Frederick, Md

19.

(Date rec'd by registrar)

19

47
Dr. J. H. Jones
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CalvertCity or town Appelton, md
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 10-12-47 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 8 to Oct 18
and that I last saw him alive on Oct 20

Immediate cause of death

Cerebral hemorrhage

Due to

Hypertension c.v.-k

Due to

Other conditions Generalized arteriosclerosis

(Include pregnancy within 5 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

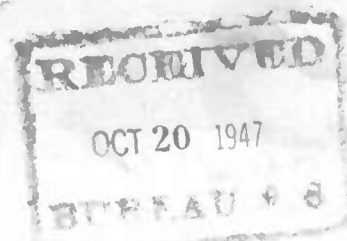
R. H. Villanueva

Address

St Leonard md

M. D. or other

Date signed Oct 11/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08896

Reg. Dist. No. 52

1. PLACE OF DEATH:

County CalvertCity or town Dunkirk
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? None

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County CalvertCity or town Dunkirk
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Elsie Lucy Trott

3. (b) Social Security Number

4. Sex F 5. Color or race w 6.(a) Single, married, widowed, or divorced widow6.(b) Name of husband or wife Clint Trott7. Birth date of deceased (mo., day, yr.) Sept 28 1886 8.(c) If alive, give age _____ years8. AGE: Years 61 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Dunkirk md
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business _____

12. Name Robert W. Hittington13. Birthplace md14. Maiden name Emma Childs15. Birthplace md16. Informant Mrs. Lucy WhittingtonAddress Dunkirk, md17. Burial Date thereof Oct 24 47
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Smithville Cem.Location Dunkirk, md18. Funeral director W. H. HutchinsAddress Dwight, md19. Oct 24 19 47 Grace L. Hutchins
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 19 47 at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____, to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death Coronary ThrombosisDue to Atherosclerosis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, list in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE Herbert W. Hittington M. D. or other _____Address Hittingtontown Date signed 12/1/47

